MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES
December 17, 2003
10:00 a.m. – 4:00 p.m.
Missouri State Capitol Building
Jefferson City, Missouri

OFFICIAL

Commissioners in attendance: Gregg Laiben, Thomas Cartmell, Deborah Jantsch, Susan Kendig, Scott Lakin, Pamela Marshall, Alan Morris, Bea Roam, William Schoenhard, Stephen Smith, Barry Spoon, James Utley, Kenneth Vuylsteke, Lori Scheidt, and Tina Steinman.

I. CALL TO ORDER

Gregg Laiben, Chairperson
The meeting was called to order at 10:00 a.m. Silent roll call was taken.

Review of Draft Minutes from the previous meeting:

Dr. Laiben noted that all Commissioners had received the draft minutes electronically prior to this meeting. One Commissioner, Nancy Kimmel, who could not be present at today's meeting sent written changes to be incorporated into the final minutes.

Linda Bohrer noted that certain grammar and punctuation errors will be corrected. In addition, MDI staff noted two substantive changes:

- On pages 8-9, MDI staff suggested that "OB-Gyn" should be replaced with "OB". Asked Dr. Jantz for her opinion. Dr. Jantz didn't think a change was really necessary.
- Page 15, MDI staff suggested that comments regarding paper vs. electronic medical records should be more clearly described, to show that different Commissioners had different views on this issue.

The minutes were approved as amended by verbal vote with no objections.

Linda Bohrer asked audience members to sign the attendance log, and also to sign a list for public comment if they wished to address the commission today.

II. JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS PRESENTATION

Noelle Brown, representative of the Joint Commission on Accreditation of Health Care Organizations – JCAHO - (handouts available) – a Not-For-Profit organization.

In addition to the information included in the written materials, Ms. Brown made the following points:

- 47 states, including Missouri, deem JCAHO accreditation as indication of compliance with state rules. No hospital is required to be JCAHO accredited. The Center for Medicare and Medicaid Services ("CMS") deems JCAHO hospital accreditation to meet CMS requirements, which encourages hospitals to be accredited. 95% of hospital beds in the US are in accredited hospitals. JCAHO accredits 17,000 organizations including but not limited to home health organizations, laboratories, ambulances, hospitals, etc.
- Cost of accreditation is high, but so is the value. Organizations unable or unwilling to take on the cost of accreditation often purchase the JCAHO standards manual, and work on their own to meet some or all JCAHO standards. Accreditation is not a requirement but it raises organizational standards.
- In Missouri, JCAHO has accredited 300 health care organizations. Of the 150 licensed hospitals in Missouri, 112 are JCAHO accredited, or about 72%. This is a comparatively low rate among hospitals within a state. One reason may be the conversion of acute care hospitals in rural areas to "critical access" hospitals, which operate, and are reimbursed, under different rules than other hospitals.
- JCAHO would be happy to provide the Commission with a copy of the hospital standards.
- A JCAHO survey is typically 3 days long. Surveys involve following a medical record through its course while the patient is hospitalized. Surveyors also observe caregivers working.
- Surveyors look at how well the staff at any given point in time matches the level of need of the current inpatients, instead of looking only at patient-to-staff ratios.
- JCAHO standards require organizations to inform a patient of adverse events even if there has been no negative impact on the patient. No state has laws on this.
- The most frequent occurrences subject to JCAHO review are suicide, medication errors, wrong-site surgery and delays in treatment.
- The goals of JCAHO's sentinel event policy are not to be punitive, but to collect information.
- While JCAHO doesn't capture anything close to the 90 thousand errors that occur annually, it's felt that what is reported to JCAHO is representative of the range of serious errors.
- JCAHO's position on mandated reporting is that "error" or "event" must be clearly defined. This is one of the hardest things to do.
- If states require root cause analysis, they should also require stated action plans to address reported problems.
- JCAHO thought it would be a great idea to issue sentinel event alerts as reports were received, to disseminate best practice information to all hospitals. However, hospitals

reacted badly to this and felt it was too burdensome. Therefore, JCAHO stepped back and refocused on a few key areas, which became the National Patient Safety Goals. Accredited hospitals must comply with the Goals.

- One problem that has been highlighted has been that a healthcare professional might work in more than one setting. The procedure for executing a safety standard in one hospital is likely to be different from procedures at another hospital. A person working in multiple settings must know and follow multiple procedures. This often leads to problems. Therefore JCAHO issued a Universal pre-op procedure.
- JCAHO gets about 20 thousand complaints a year, and acts on all of them. JCAHO may ask the organization to respond, or make an unannounced survey, or trend complaints to identify system problems.
- Many states are demanding hospital rankings, but are failing to understand the importance of having standard risk adjusters. For example, a law in Illinois creates unfair ranks. The law focuses on morbidity and mortality measures. Hospitals with a high rate of serious injuries are not distinguished from hospitals that don't treat severely injured patients.
- JCAHO is working with CMS to develop a "Hospital Quality Report", which will be free to the public. The report is projected to be released in 2004 and will be much more detailed than currently available JCAHO reports.
- Two goals of the Quality Reports are to encourage hospitals to improve their performance, and also to demonstrate to the public what accreditation means and where quality of care is important.

OPEN DISCUSSION:

What is the time frame in which an accredited hospital must inform a patient about an adverse event? A: JCAHO standards don't specify a time frame.
If JCAHO gets a complaint from a patient, and it turns out the patient was involved with an event the hospital should have reported but failed to do so, what does JCAHO do?
A: Reporting to JCAHO is voluntary. Regardless of the source (patient or hospital), JCAHO's response is to ask the hospital to do a root cause analysis and come up with an action plan. However, the hospital must inform the patient of the outcomes of care, whether or not the patient was harmed. If the hospital failed to tell the patient, then JCAHO would act to assure the hospital didn't repeat this failure in the future.
If errors are not corrected, what then? How would JCAHO assure no future failures to inform the patient? A: The hospital would be put on an adverse accreditation decision track, which would involve assuring that the hospital's policies are changed and personnel are trained with regard to the requirement to inform the patient. As far as enforcing the standard, an adverse accreditation decision is the only penalty JCAHO can impose. They would be put on an accreditation watch. Loss of accreditation can affect Medicare reimbursements.
How often does JCAHO deny accreditation? A: About 2% of the time. Organizations that are denied accreditation can take steps to regain accreditation.
Newspapers pick up denials, etc. Are denials on JCAHO's web site? A: Yes.

JCAHO's hospital quality report card is very different from the one produced earlier this year by Kansas City area hospitals. Is there enough coordination going on with regard to various reporting and ranking efforts? Will consumers really use all these reports?
A: Can't answer, but it's a very good question. Hospitals should be involved with setting the standards against which they will be measured, because organizations like Leap Frog aren't fooling around. State agencies should also get involved, particularly with regard to identifying information that's important to consumers. States shouldn't start their own reporting efforts from scratch. Colorado is an example of a state that tried to do this, but failed. New York is an example of a state that has implemented two mandatory reporting areas.
Does compliance with the safety goals impact accreditation? Is it working?
A: Yes, compliance will impact accreditation. Any time JCAHO is involved with a hospital, compliance with the safety goals will be evaluated, whether it's a survey or a complaint investigation.
Only 72% of hospitals in Missouri are accredited, but what about the other settings where surgery occurs? The orthopedic societies have determined that the majority of wrong-site surgeries are orthopedic surgery procedures, particularly knee arthroscopies. These operations aren't done in hospitals. If JCAHO is evaluating hospitals for compliance, what good does that do when most surgery is taking place in other settings? What percent of clinics, ambulatory surgery centers and doctors' offices are accredited?
A: This is a big problem, related to the way states license and regulates non-hospital surgery settings. Different settings in the continuum of care are treated differently. 15 states don't license ambulatory surgery centers at all, although Missouri does. The Boards regulate office surgeries for medical professionals, and doctors are licensed to sedate patients in their offices. JCAHO offers accreditation for these settings, but these settings don't have the same reimbursement encouragement to get accreditation that hospitals have. A list was provided to Linda Bohrer showing 16 ambulatory surgery centers and 2 doctors' offices that have JCAHO accreditation in Missouri. States don't even realize there's a problem with these settings because there is no effort to collect data. Lois Kollmeyer noted that there are 70 licensed ambulatory surgical centers in Missouri. An ambulatory surgery center is not required to be licensed at all unless 51% of their business is surgical. *Ms. Brown* noted that providers could deliberately avoid licensure by limiting the percent of their business that is surgical.
Is there any data that shows whether or not accredited organizations are safer than non-accredited organizations?
A: There is very little data. A study of long-term care centers undertaken about 2 years ago indicated that accredited organizations were safer than non-accredited organizations, but this was a limited study. The study was funded to show insurers that accreditation paid off.
What is the cost of reporting sentinel events?
A: There is no charge for reporting. The only charge is for accreditation, which encompasses all activities that may occur from one accreditation cycle to the next.
How does JCAHO assure that root cause analysis and action plans won't be discovered?
A: JCAHO accreditation is handled by contracting with the organization. The contract prohibits disclosure to unaffiliated third parties. States can require licensed health care

providers to report to an agency, but cannot require JCAHO to report to an agency. New Jersey and Kentucky are challenging JCAHO about this.
How is JCAHO specifically handling the issue of look-alike/sound-alike drugs, especially with more and more generics being used where there's no standardization of packaging or production? A: JCAHO has no direct influence over drug makers. However, there is staff dedicated to working with drug makers on these issues. Because JCAHO requires accredited organizations to address potentially vulnerable areas and processes, drug manufacturers may be pressured by hospitals to make safety related changes. Darryl Rich would be the person at JCAHO to talk to.
Is data from voluntary reporting published? Is that all JCAHO does with it? Is JCAHO aiming only to change behavior? A: Sentinel event data publishing has two goals. First JCAHO wants to ensure that root cause analysis and correction occurs. Second, JCAHO wants to disseminate information for the public and other providers to learn from.
How do you know that people who need the information are actually reading the reports? A: The National Patient Safety Goals are based on the sentinel event data because that data was both evidence-based and practical. So, accreditation is the incentive that assures people who need to know pay attention to the reports.
Is JCAHO making patients safer? A: JCAHO wants reporting to go up so that statistically significant data can be accumulated that will answer this question. It will take time for sufficient data to be collected.
Is Missouri a mandatory reporting state? Could the Commission get model legislation to look at? A: Missouri is not a mandatory reporting state at this time. JCAHO can provide a list of the states where reporting is mandated. Review of the laws of those states might provide a model for Missouri.
Does JCAHO do surprise visits? A: Yes, but currently only 5% of accredited organizations are randomly selected each year for unannounced visits. The current process is that JCAHO tells a hospital when to expect the surveyors for the regular survey and accreditation cycle. In 2004, JCAHO will solicit volunteer hospitals to survey on an unannounced basis for the regular survey, in addition to the 5% randomly selected each year. In 2006, all regular surveys will be unannounced.
With regard to coordination with state agencies, what should the Commission recommend to improve this process? A: JCAHO finds little benefit to sharing all complaint and survey data with state agencies. JCAHO will tell a licensing agency if an adverse accreditation decision is made or if JCAHO feels there is immediate jeopardy to patients. However, except for unique agreements with the state of New York, no state law compels JCAHO to report to state agencies. JCAHO would not support the benefit of doing so.

III. MISSOURI HOSPITAL ASSOCIATION PRESENTATION

Becky Miller, Missouri Hospital Association, and Bill Schoenhard, SSM Healthcare (handouts available)

Ms. Miller began by addressing one of the questions that was asked of Ms. Brown. Why relatively few hospitals in Missouri had JCAHO accreditation. Most of the non-accredited hospitals are small rural hospitals with "sole community provider"

designation. These hospitals have limited competitive pressure to be accredited, and they also are not as pressured by managed care to be accredited. Therefore, some hospitals may see the costs of accreditation exceeding the benefits. Many of these hospitals use the JCAHO tools and standards, even though they don't seek formal accreditation. In other states, even bigger and more metropolitan hospitals are starting to forgo accreditation due to cost. Missouri is not yet seeing this trend, but weighing of costs and benefits of activities are something all hospitals must consider.

In addition to the points from the slides, Ms. Miller and Mr. Schoenhard made the following points:

- Missouri is unique in that one state-wide hospital association has all licensed acute care hospitals as members as well as many specialty hospitals (i.e. rehabilitation and psychiatric). This allows MHA to obtain information from a large number of Missouri's healthcare providers through surveys and data collection activities. One area they have investigated is the patient safety program in Missouri hospitals. Survey results are available, but they reflect information from 2000. A lot has changed since then.
- Studies looking at nurse staffing issues indicate that adequate hospital reimbursement is needed to help hospitals attract and retain good nurses in adequate numbers.
- As patients move from provider to provider within the health care continuum, coordination of care is imperative. For example, the use of hospitalists has both positive and negative elements. The hand-off of information when a patient is discharged back to their PCP is an area of concern that requires ongoing communication.
- The Missouri Hospital Association supports the Federal Patient Safety bills that have been introduced in Congress. These bills foster development of patient safety organizations and protect their activities. While Missouri's peer review laws offer protections, it is limited to activities performed within the peer review process and not other quality and safety related data collection and analysis.
- The American Hospital Association is an example of an organization that has lead patient safety activities that MHA has coordinated with to distribute materials to hospitals in Missouri. Copies of the American Hospital Association's "Strategies for Leadership" are available from AHA's website at: http://www.hospitalconnect.com/aha/key_issues/patient_safety/whatsnew/strategiesforleadership.html.
- Among the competing priorities facing hospitals are huge capital expenditures needed just to maintain aging plants. Hospitals have limited resources and competing priorities to address patient safety. Moving providers to electronic medical records is extremely expensive and difficult. It's also not funded.
- Hospitals can launch vigorous safety programs, but they don't employ physicians and can't always control physicians' buy-in.
- MHA currently has a data collection project that provides participating hospitals quarterly data on certain clinical areas. A national set of indicators established by the Agency for Healthcare Research and Quality is being adopted for this project that will include inpatient indicators as well as patient safety indicators. The

current project will be converted to use of the new measures July 2004. This is an example of the type of work that can be performed by a private entity with provider buy-in.

- The Commission cannot fix safety without doctors. Doctors are under siege with regard to medical malpractice insurance.
- The Commission must address the multifactorial nature of patient safety, and all the provider types in the continuum care, including long term care, involved. This is true because hospitals don't actually have the patient very long anymore. Other providers have a big role in how safely a patient is treated. Hospitals can't be the sole focus of safety issues.
- A pure public effort to address patient safety is likely to kill private initiatives. This would be detrimental to Missouri's efforts to improve safety. The Commission should learn from and emulate the blend of public and private effort that Georgia has experienced and states that have obtained protection for such work.
- MHA believes an excellent national framework is being developed on the issue of improving patient safety in hospitals. MHA is tapping into this national framework on behalf of Missouri hospitals and is interested in working with other provider groups on this important topic. MHA is very interested in the final recommendations of the Commission and will aid the Commission in every way possible.

OPEN DISCUSSION:

What kind of educational material do patients get on how to be active in their own care, and when do they get it? Is accreditation linked to providing educational materials?
A: JCAHO and CMS have developed materials. Numerous other organizations have developed materials. All hospitals post a patient's bill of rights and responsibilities. Educational information is not usually provided before admission, but sometimes it might be provided in a pre-operative visit. Accreditation is linked to providing educational materials.
How can we move providers to a culture of safety as emulated by Missouri Baptist or SSM? Is public reporting the way? Are there other ways? A: Voluntary reporting is one aspect. Stakeholders must come together and prioritize the issues. The Commission has an important roll to play in prioritization, and should understand that not all problems can be fixed at once, as JCAHO learned.
Dr. Jantz commented that an independent practice association of physicians in the Kansas City area is beginning to talk about producing report cards. This effort is in its infancy. Is this going to be just more paperwork, or is there going to be improvement from this kind of effort? A: It's hard to do, but providing more information to the public does effect change.
Why are hospital patients sicker than in years past, and what is the value of hospitalists? Some managed care companies don't reimburse PCPs for hospital-based procedures because they are forcing members to be cared for by hospitalists. Is this a good thing?
A: Hospitalists are a medical specialty like any other. Hospitalists are typically staff doctors who have chosen to limit their practice to inpatient care. Usually hospitals and

PCPs have agreements with hospitalists regarding the hand-off of patients and patient information as patients are admitted to and discharged from hospitals.

The Commission broke for lunch at 12:35, and reconvened at 1:15.

Following lunch, **Dr. Laiben** announced that Linda Bohrer's report would follow the presentation from Walgreen's.

IV: PRESENTATION ON THE PHARMACISTS VIEW OF PATIENT SAFETY CONCERNS AND ACTIVITIES

Audrey Hudson Neely, Mgr., Professional Affairs Walgreen Co

Audrey Hudson Neely presented on the safety improvements that Walgreen's has initiated in their national chain of pharmacy stores. (Handouts available) In addition to the information from the handouts, Audrey Hudson Neely made the following points:

- Walgreen's launched their safety initiative in Florida and Texas because those states have legal protection for providers investigating their own errors. Even with protection, there was still considerable professional resistance to the idea of reporting errors and near misses. Walgreen's has worked to overcome this resistance, and is planning on rolling out the program to all pharmacy stores nationally.
- Walgreen's safety initiative establishes the expectations that all pharmacies are expected to meet. Policies and procedures are available on Walgreen's Intranet to all stores. The program revolves around standardization of work processes and also work environments. At this point, the oldest Walgreen's store is 5 years old. All stores have been remodeled to conform to a standard work area design, to the extent the footprint of the building permits.
- Even though Walgreen's definition of an "event" is stated and readily available to all employees, it gets interpreted differently in different shops. This is a very difficult area to grapple with.
- Pharmacy technicians at Walgreen's do 80% of the work. A few core tasks are stated as the areas where pharmacists should do the work, such as drug utilization review and patient consulting, but technicians carry out all other work.
- Walgreen's seeks and rewards employee input. A Missouri pharmacist had an idea for better handling of look-alike/sound-alike drugs. This idea was instituted nationally, and the pharmacist received a $10,000 bonus for the idea. After the bonus was awarded, the number of employee suggestions skyrocketed.
- Walgreen's program includes root cause analysis on any reported errors. Errors include both "internal" (did not reach the patient) and "external" events.
- Walgreen's is the only pharmacy company that nationally requires technicians to be certified by the national Pharmacy Technician Certification Board. Illinois is the only state that has a state law mandating PTCB certification. One unintended benefit of requiring the certification is that theft of drugs from the pharmacies went down.

- Walgreen's has a nationally linked computer system that provides a patient profile for every person that gets a prescription filled at Walgreen's. The information is updated every 3 seconds, and includes both a picture and a verbal description of the medicine the patient is supposed to receive.
- One element of the system is a scanning process that matches the drug to the prescription, and doesn't allow a prescription to be purchased if the scan check hasn't been performed. This is a successful forcing function that has reduced errors in filling prescriptions.
- Walgreen's struggles with the dilemma of gathering and keeping enough information to learn from errors, while also protecting itself from litigation. Even though most states don't have the kind of protection Walgreen's would like, the company is committed to using its safety program nationally. The company is actively pursuing legislative protections.
- In some high-volume stores, Walgreen's has robots filling, labeling and verifying prescriptions. At other stores, Walgreen's is planning to develop a flagging system that will alert a cashier or manager if the technician fails to perform a required verification process. The hope is that the system will combat simple human failure to follow work-flow processes.

OPEN DISCUSSION:

How does Walgreen's reward error reporters? A: Rewards should be given at the store level, when investigation and root cause analysis takes place. Employees are starved for recognition and store managers are responsible for providing it.
How does Walgreen's teach employees to do root cause analysis? A: Regional managers are taught, but RCA is very simplified at this point in time. It's not always done, or done well. Walgreen's has a standard work-flow process that, if followed, will not allow errors to occur. However, it's not always followed. Teaching employees to think in new ways is the key. Reporting goes way up when staff start to understand the importance of learning from errors.
Does Walgreen's have self-insured or Exclusive Provider Organization contracts? If so, how does Walgreen's protect privacy? Do payors get information from the patient profile in Walgreen's' system? A: Walgreen's has self-insured and EPO contracts. However, payors don't get the profile information. Patients can be mailed the information if they request it. Some payors also perform their own utilization review. In these cases, the payor has personal health information about patients, but the patient has authorized this access. Walgreen's is very aware of their HIPAA privacy obligations.
Is Walgreen's' patient profile system proprietary? Can other companies use it? Can Walgreen's import information that other pharmacy chains might have when patients change from one health plan to another? If not, do pharmacists have to learn different systems every time they change where they work? A: Walgreen's' system is proprietary. Other chains probably have their own systems and would be reluctant to share information. Pharmacists, like any other person, have to learn the systems used by their current employer, no matter who the employer is. It's also fair to say that continuity for the patient is compromised when patients change from a plan with another chain as the pharmacy provider, to a plan with Walgreen's as the pharmacy provider.

If a customer is new to Walgreen's, can Walgreen's get a patient history of any kind?
A: Only if a payor is involved that can provide that information.
Is the layout of all stores standardized? If so, what prompted Walgreen's to do this?
A: As much as is physically possible, all store layouts are the same. Both safety and business concerns prompted Walgreen's to do this. Fear of liability drives a lot of business decisions.
Are prescriptions all hand-written? Will Walgreen's move to all prescriptions being printed or electronic? A: In the Missouri market, most prescriptions are hand-written. Some markets, like Arizona, are moving more to printed or electronic prescriptions. Walgreen's has put computers in doctors' offices. This system was sold to another company, and only worked for refills. The system was found to be illegal in Wisconsin. All stores are able to receive electronic prescriptions. In most cases, it's more practical to use fax machines if the patient doesn't carry the prescription in.

V: RESEARCH FROM OTHER STATE PATIENT SAFETY COMMISSIONS/ORGANIZATIONS

Linda Bohrer, Dept. of Insurance support staff for the Commission.

Linda presented greater detail on the patient safety activities on other states. She did not have a visual presentation, but provided a brief summary of MDI's findings.

In addition to the information on the handout, Linda discussed the following items:

- MDI understood the request of the Commission to be to find out how similar bodies in other states had operated, particularly how long they had functioned, how they were funded and spent money, and what has come about since those bodies were first instituted and concluded their work. See attached list of standard questions that MDI attempted to address in each case. Getting answers to all these questions wasn't always possible.
- Numerous attempts were made to find a person in Illinois that could speak to the efforts of that state. We were unsuccessful in finding anyone in IL with historical knowledge about the patient safety commission. It was not possible to gather the kind of operational insight from Illinois, including activities since the commission was disbanded, that MDI was searching for. MDI apologizes particularly to Dr. Morris, who had especially asked for information from Illinois.

Dr. Morris noted that the apparent obscurity or total lack of a person that can speak about the Illinois efforts in fact speaks volumes about the kind of follow-up that has probably occurred in that state, and graciously accepted MDI's apology.

Linda's notes on her presentation:
MARYLAND: **The Maryland Patient Safety Coalition**
It is a coalition set up in 2000. Directed by legislation and is an ongoing coalition. Made up of about 30 members of health professionals, hospital association, insurance industry, and state boards. The legislators were also invited to the meetings. Meets once a month for about 2-3 hours. Maryland also has the Maryland Health Care Commission

that works directly with coalition. The Department of Health and Mental Hygiene consults with the coalition.
The coalition got information on a variety of reporting systems in place in New York, Massachusetts, and Pennsylvania. These systems vary in the type of event that needs to be reported, the outcome of the reports (how they are investigated and what the regulators do with the information) and the confidentiality of the information. As a result the coalition developed mostly reporting requirements that include RCA reporting. They are trying to develop a voluntary reporting system for less serious errors. Established a requirement to have a PS director at all Maryland hospitals. It does not have to be that person's only role in the hospital. They are rewriting the state regulations on risk management (required in hospitals). The coalition developed a survey to capture information from a variety of health care settings (hospitals, nursing homes, providers, industry) to get a picture of what is happening in the state in the area of patient safety. The commission is handling the survey Subcommittees were established within the first two years of operation. A task force to work with the pharmacy board and focus on medication errors and possible solutions was established. They came up with some substantive solutions to work within the existing framework of Maryland regulations. They dealt with the issue of continuing education, whistle-blowing protections, and public access to patient safety investigations.

TENNESSEE: **Tennessee Improving Patient Safety Coalition (TIPS)**
The Health Data Reporting Act of 2002, effective in August 2001 mandated a report to be made to the Governor in May 2002 on unusual events occurring in hospitals. The Dept. of Health had to provide the report summarizing the type and number of unusual events in the state's hospitals. Because of the mandate in the Act, reporting is a primary focus in TN. There were several more outcomes resulting from the work the Dept. of Health did in implementing this act. It was originally a temporary board that proposed permanent changes to regulations and established a permanent Patient Safety board. They defined "unusual event", developed a tracking system for the required reporting, revised rules for reporting "unusual events" and established the TIPS Coalition. It is a voluntary group of healthcare stakeholders and was established in August 2001. The coalition is made up of about 30 professionals, industry associations, consumers and regulatory boards. During their first year the TIPS coalition recommended the adoption of five best practices that they felt were identified through the mandatory reporting act information. The TIPS Coalition and the Dept. of Health seem to be working simultaneously on the issues of patient safety. There has been a strong educational effort to promote and educate professionals on the issue of patient safety concerns and corrective programs. TIPS identified 4 objectives within the first year of work. These are broad objectives such as 1. Providing ongoing leadership in health care quality improvement. 2. Collaborate and coordinate patient safety efforts within the state, with other state agencies and with other states. 3. Develop and review any possible best methods for data analysis and reporting. 4. Identify materials on preventing health care errors, patient safety and quality improvements that state regulatory bodies, purchasers, professional associations and societies, health plans, and licensed health care facilities can disseminate, reprint or adopt.

TIPS divided into subgroups after about a year. They staffed out of the Department of Health and they are not budgeted. They are trying to get grants to fund an educational summit they are trying to put on in 2004. They meet quarterly and have an education piece at each meeting in addition to the initiative work that they recommend. They are focusing on "best practices" and "educational approaches" to the issue.

CONNECTICUT: **Quality in Health Care Advisory Committee**
This committee is an outcome of Public Act 02-125 in 2002. The work was conducted by the Department of Public Health through a required quality of care program. It has a broader focus than exclusively patient safety. The act mandated measurement and public reporting of patient satisfaction and clinical performance measurement in hospitals. Mandatory adverse event reporting was part of the Public Act requirements. The Department established an Office of Health Care Quality and Best Practices. The Committee advises the Quality of Care program on its activities. There is a relationship between the Dept. of Health, the Quality of Care Advisory Committee, the Quality of Care program and the Office of health Care Quality and Best Practices, but it is a little confusing and I haven't been able to sort that all out. The Commissioner of the Dept. of Health chairs the committee. It is made up of other state agencies, hospitals, health plans, patient advocates, university representatives, businesses, and health professionals. The makeup is mandated in law. The committee began its work in 2002 and immediately established subcommittees to deal with 1. Health promotion and prevention. 2. Continuum of Care. 3. Regulation changes. 4. Promotion of Quality and Safe practices. The Public Act language drove the identification of the Subcommittees. Several working groups were established under each committee. The subgroups make recommendations to the full committee who take action on the recommendations. The committee meets quarterly.
There is an extensive list of the breakdown of the activities of each subcommittee. The Advisory Committee is not budgeted for funding.

PENNSYLVANIA: **Pennsylvania Patient Safety Authority**
This is an 11-member board that first met in 2002, and they continue to meet. The Gov. and the legislative bodies appoint them jointly. The board is made up of health care professionals, attorneys, and a non-health care worker. It is considered an independent state agency. They meet about once a month. It is staffed by state paid employees since it is considered a state agency. It is funded with dedicated state funds called the "patient safety trust fund" independent of general revenue. Funding comes from a licensing fees charged to licensed medical facilities that report to the Authority. They had almost a $5 M appropriation the first year of operation. The mandated statewide reporting system for adverse events was the first job the Authority tackled. This took a year to implement. They found the time they took for listening to the issues and problems was helpful.
The Department of Health initiated the legislation that developed the Authority and this was a direct outcome of the 1999 IOM report. The law specifically asks the Authority to recommend statutory or regulatory changes that will improve patient safety, but they have not had time to focus on that yet. They have been concentrating on the reporting components of the law. The Physician General of PA is the Chair of the Authority and

would like to visit with the Missouri Patient Safety Commission on PA's work in this area. He cannot come after February due to activities going on in PA with patient safety.

FLORIDA: **The Florida Commission on Excellence in Health Care.**
This commission most closely resembles the format in Missouri's. They made recommendations for change, some of which were legislative. It took two years in some cases to get the changes implemented. The 2000 legislature created the commission. They operated for one year. (July 2000 to June 2001). It is made up of 41 members. Its membership consists of regulators, medical professionals, lawyers, malpractice insurers, consumer advocates, health insurers, legislators and medical schools. They met monthly for 7 months. It was staffed by the Dept. of Health and was funded for travel only through the state budget. The University of Miami received funding to conduct legislatively required studies. Their initial four meetings were educational in nature but they did divide into subcommittees right away. The subcommittees looked at 1. Quality Measurement/Data collection and reporting. 2. Regulation and 3. Education/Best Practices. Subcommittee recommendations were presented and discussed at the next two meetings. Motions and voting on the recommendations were done at the 7th meeting. The commission had 7 months to conduct its work and present recommendations to the Governor and other elected state officials. Some of the recommendations took the form of legislation that was passed in 2003. A Center for Patient Safety was established as an outcome of the commission's legislative recommendations. The law establishing the Center for Patient Safety also has some mandatory reporting requirements for adverse events. It does not clearly protect entities from liability related to required reporting. The law addresses tort reform, medical malpractice premiums, and consumer information on provider selection.

Dr. Morris noted that Pennsylvania is a compelling state to look at because that state was experiencing a severe crisis in medical malpractice rates about 2 ½ years ago, around the same time the Pennsylvania legislature passed laws establishing the Patient Safety Authority.

Ms. Bohrer asked if any Commissioner wanted additional research pursued on any other states' activities in the area of patient safety. No request was made.

The Commission took a break at 2:30 and reconvened at 2:55.

VI: GENERAL DISCUSSION ABOUT THE FUTURE OF THE COMMISSION:

- Draft agendas for the next three meetings were distributed. Dr. Laiben reminded Commissioners to be thinking about their statements from the first meeting regarding areas the Commission should focus on and what should be in the final report. Commissioners should consider whether or not presenters lined up for the next 3-4 meetings fit with the initially stated focus areas. Also, free time in the agendas needs to be filled. **Commissioners should think about whether to divide into subcommittees, bring in additional presenters, hold discussions as one single body, or something else.**

- **Dr. Smith had some ideas. First, information still needs to be gathered. Second, establishing certain criteria: a non-punitive environment, anonymous reporting, legal protection for error admission and investigation and whistle-blower protections, should encourage reporting. Third, mandatory reporting should be considered, perhaps through existing channels such as JCAHO. Fourth, hospitals should have patient safety officers in charge of root cause analysis, and responsible for reporting to a central organization or state agency.**
- Are there any presenters scheduled on the topic of mandatory event reporting? Ms. Bohrer confirmed that there is not, but that representatives from New York indicated a willingness to come, and there is money available to help cover expenses to bring a presenter from New York.
- **Will there be a point at which the Commission coalesced around some key points? For example, can the Commission generally agree that a non-punitive philosophy is a foundation for improving efforts to prevent future errors? If so, a presentation on mandatory reporting might not be necessary. Alternatively, is the Commission generally in agreement that there should be some kind of permanent body to carry on the work begun by this Commission?**
- **A time-limited body such as this Commission almost has to recommend establishment of a permanent body, where additional stakeholders can participate. There has to be a recommendation regarding protection for providers that openly investigate and learn from errors. One innovative option to consider is a trade-off, where protection exists for providers that report their own errors within 24-hours, but providers who do not face triple damages.**
- Is non-discovery the same as peer protection? Dr. Smith felt that his recommendation would be much broader than current peer protection laws. Peer protection doesn't exist for any provider that is not somehow licensed by the State.
- A presentation on the laws, regulations and case law for Missouri's current peer review law should be done. It was agreed that a presentation would be beneficial, noting that the current laws have some big loopholes in them. It was agreed the Attorney General might be the best possible source for a presentation on this subject. Ken Vuylsteke agreed to take the lead and line something up for a presentation on peer review laws.
- **Any recommendation or work the Commission puts into peer review protections should be multidisciplinary. Several Commissioners agreed that recommendations of the Commission should address the entire continuum of care.**
- **It was suggested that event reporting encompasses the entire continuum of care. A state agency could compile data, identify trends, and categorize reports. Such a board should be diverse and should have some powers related to formulating remedial action plans to address errors. Such a board could have any number of ex-officio member experts representing the entire**

continuum. Such a board should be responsible for disseminating information on best practices, perhaps through continuing education.

- Mandated topics within the 2-year continuing medical education cycle has been tried before, and was not tolerated by medical professionals. Any topic that becomes mandated will raise criticism from professionals in different areas who feel they're wasting their time. Offering choices that cover all areas would be one way to limit such criticism. **Dissemination of information should rely on multiple and diverse ways of communicating. CME is one option, but partnering with various organizations offers different avenues, such as addressing safety issues in the medical and nursing schools.**
- There was discussion that the Commission was talking about solutions before really defining the problems. Looking at what other states have done suggests a framework for defining problems, but that data is required to make clear definitions. A time limited Commission can't define all the problems. What level of detail should a problem statement have? **It was suggested that a high over-view level of detail is most practical. The value of stating problems is that the statement is likely to point to possible solutions. For example, should the Commission ask the legislature to look at more comprehensive and centralized data reporting?**
- It was noted that Scott Lakin's experience as both a legislator and a bureaucrat makes him very valuable to the Commission. Commissions and committees will be increasingly important in years to come because legislative expertise in any particular area is eroded by term limits. Outside bodies will become the source of policy decisions. This Commission has an opportunity to make some dynamite proposals because of the expertise it offers. The Commission can also call on a broad base of support, which will make any recommendations more attractive to legislators. Also, the experience of other states is informative, but issues specific to Missouri should be the primary focus.
- After discussion on the desired format of upcoming meetings, Scott Lakin suggested all Commissioners start drafting problem and solution statements, and to set some time aside in each of the upcoming meetings to put various statements up on the wall for discussion. Several Commissioners felt this was a good idea, because it combined spending time on educational presentations with time spent towards a final product.
- Linda Bohrer stated that MDI staff will try to get presenters on mandatory reporting, peer review protection in Missouri today, malpractice insurers' perceptions of patient safety and liability and patient safety in doctors' offices. Ken Vuylsteke volunteered to make contact with a person he feels has expertise in the area of malpractice insurers perceptions - Tim Trout.
- Dr. Laiben asked if the Commission still wished to take a closer look at MDI's med mal data, through a subcommittee. Dr. Spoon suggested that the proposal be discussed after the Feb. 4, 2004 meeting. Dr. Laiben directed Linda Bohrer to add this as an agenda item for that meeting.

The meeting was adjourned at 4:35 by acclamation.

Questions MDI asked in other states:

1. How long has your commission/board been functioning?

2. How many members does the commission have?

3. What is the makeup of the membership? (medical professionals, lawyers, insurers, corporate/hospital executives)

4. Are state agencies represented on the commission? Which ones?

5. How was it established? (Executive order, private/public partnership/legislatively, etc)

6. When did you begin working?

7. How often did you meet at the beginning? How often do you meet now?

8. How is the commission staffed? (Volunteers, appointed positions, paid staff?)

9. How is it funded? (Privately, publicly, grants) If publicly funded, through which state agency? If privately funded, which types of businesses are supporting the commission?

10. What is your budget? What are you spending?

11. Are you encountering budget battles and how much time do you invest in the battle?

12. How much time was spent on investigation of the problem and what is happening in the real world before moving to the solution phase?

13. Who all did you bring in for presentations during the learning phase? How did you educate the Commissioners on the issue of patient safety?

14. How did you move from learning the issue of patient safety to designing your action plan?

15. What form did your outcome take? (Recommendations, legislative proposals, funded patient safety projects, establishing a permanent commission)

16. When was the initial outcome product produced?

17. What is the progress on implementation of the outcome recommendations?

18. Who is responsible for follow-through on the outcomes? And how?

19. For continuing Boards/Commissions, How are changes to the membership handled and how are changes to the leadership handled?

20. Availability to present to Missouri's Commission

21. Other comments/ thoughts/insights